

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33141.

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town PINE LAWN
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4604 ROSEWOOD AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 years (Specify whether years, months or days)
In this community 9 years

3. (a) PRINT FULL NAME LYNN H. WALLACE

3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCT 9 1930
(Month) (Day) (Year)

8. AGE: Years 9 Months 11 Days 4 If less than one day hr. _____ min. _____

9. Birthplace ST. LOUIS COUNTY, MO
(City, town, or county) (State or foreign country)

10. Usual occupation SCHOOL CHILD

11. Industry or business _____

12. Name JAMES ELWIN WALLACE

13. Birthplace UNION MO
(City, town, or county) (State or foreign country)

14. Maiden name ETHEL JONES

15. Birthplace FENTON MO
(City, town, or county) (State or foreign country)

16. (a) Informant James Elwin Wallace

(b) Address 4604 Rosewood Ave

17. (a) BURIAL (b) Date thereof SEPT. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM

18. (a) Signature of funeral director L. B. Tanner

(b) Address 107 Natural Bridge Rd

19. (a) SEP 16 1940 (b) R. M. Myers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town PINE LAWN
(If outside city or town limits, write "RURAL")
(d) Street No. 4604 ROSEWOOD AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year 40 hour 11:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug. 12th

_____ 19 40 Aug. 31st 19 40

that I last saw him alive on Aug. 31

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cardiac decompensation.

Due to _____

Rheumatic heart disease

Due to _____

Other conditions 95
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)

(Means of injury) _____

23. Signature Dr. J. Smith (M. D. or other)

Address 4930 Lindell

Date signed 9/14/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Stanley H. Dixon, Registered Apprentice No. 214
working under my personal supervision.

Signed J. G. Sullivan
Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.